Healthcare Risk Management®

Celebrating our 26th year as your first source of risk management information

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

AUGUST 2004
VOL. 26, NO. 8 • (pages 85-96)

Underwriters are demanding more and looking more closely for potential flaws

Self-assessments help prepare for their visit, show ways to improve

Insurers continue to exert pressure on risk managers, and industry leaders say you should be getting a closer look from underwriters than you have ever had before.

The latest example comes in the form of underwriters who may poke around your facility looking for any flaws that might signal a liability exposure. This kind of scrutiny often turns up problems that the insurer can use to justify higher premiums, coverage restrictions, or nonrenewals, so risk managers are well-advised to take action before the underwriters knock on the door, says **Kenneth W. Felton**, RN, MS, FASHRM, senior vice president and health care practice leader with Webster Insurance in Waterbury, CT. He addressed the topic recently during an audio conference sponsored by the American Society for Healthcare Risk Management (ASHRM) in Chicago. Felton is a former hospital risk manager.

Risk assessments have become an integral part of the underwriting process, more so in the past few years, he says. Changing market conditions in the insurance industry have forced insurers to take a hard look at health care providers before they offer coverage, Felton says, so risk managers must be ready for a close inspection.

"Underwriters use risk assessments to identify exposures," he says.

"In many cases, they will look at high-risk areas like obstetrics or bariatric surgery and will consider whether the units are too big or too small. They will review the practitioners' credentials and who is allowed to practice there. They will look at the consistency of the units on-site and off-site, looking for consistency among policies and procedures."

More comprehensive looks

The underwriters also will focus on claims experience and incident reporting processes. Then they will use all that information to make critical decisions such as whether to offer terms and conditions, the attachment point,

and whether to reduce limits, Felton explains.

"Underwriting requirements have become much more disciplined, comprehensive, and stringent," he says. "Many insurers are requiring assessments now, and I'm sure many of you have experienced during your last renewal significant increases in the amount of information you must provide."

Insurers sometimes perform risk assessments targeted to specific areas, but Felton says it is becoming more common to see "holistic" or "enterprise-based" assessments that seek to analyze the risk with a more global view.

"Nowadays, underwriters specifically want to look at your risk management program and how well you integrate risk management and continuous quality improvement," he says. "They want to know that when they sit down to evaluate your risk and exposures that they're dealing with an institution that has a commitment from the top down to deal with risk and quality improvement issues. This is extremely important."

The risk manager must present proof of such a commitment to the underwriter, Felton says. Take senior leaders from quality improvement and top administration to meet with the underwriters, and come prepared with documentation showing how your organization is addressing issues that affect risk exposure, he suggests.

"When you have face-to-face time with an underwriter, they can associate your institution with your face and they are more apt to look at your submission sooner than others they just receive through the mail," Felton explains.

Assess yourself first

The best way to be ready when those underwriters show up, he says, is to conduct your own self-assessments — often and thoroughly. That idea is seconded by **Donna Young**, CPHRM, FASHRM, vice president of risk management services with Mutual Insurance Co. of Arizona in Phoenix. She also spoke at the ASHRM audio conference and notes that ASHRM offers a self-assessment tool on its web site at www.ashrm.org.

Many insurance carriers also will provide forms and other resources for conducting self-assessments, Young says. To illustrate how a risk manager might conduct a self-assessment, she focuses on one area that she says is often overlooked and might raise a red flag with underwriters: exposures in the ambulatory care setting.

Hospitals and health care groups are buying more physician practices and ambulatory care clinics, but risk managers may be lagging behind in assessing the risk exposure, Young notes. Underwriters will zero in on that danger, she warns.

To conduct a self-assessment, the first step is knowing what to look for in your own organization. Young notes that, according to data compiled by the Physician Insurers Association of America (PIAA), 30% of all malpractice claims occur in the physician office practice, and 70% of those relate to

Healthcare Risk Management® (ISSN 1081-6534), including **HRM Legal Review & Commentary**™, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Healthcare Risk Management**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. -6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $495. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 18 CE nursing contact hours, $545. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

Healthcare Risk Management is approved for approximately 18 nursing contact hours. This offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

In order to reveal any potential bias in this publication, and in accordance with the American Nurses Credentialing Center's Commission on Accreditation guidelines, we disclose that Consulting Editor Bishop and Editorial Advisory Board members Archambault, Dunn, Porto, Sedwick, and Trosty report no relationships with companies related to the field of study covered by this CE program. Board member McCaffrey is an officer and member of the American Society for Healthcare Risk Management. Board member Kicklighter reports involvement with ECRI and Kendall Endoscopy Surgical Center. Board member Metcalfe is a consultant with Sharyn O'Mara & Associates. Board member Johnson did not complete a disclosure form.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Greg Freeman**, (770) 998-8455.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@thomson.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

For questions or comments, call **Greg Freeman**, (770) 998-8455.

diagnostic problems, usually failure to diagnose.

"When we look closely at the individual cases, there is a common thread to the contributing factors that lead to these failure-to-diagnose claims," she says. "Inadequate communication is No. 1. This includes inadequate communication between the physician and patient, particularly in the history-taking process, and inadequate or no communication between the physicians."

Look beyond hospital walls

Other communication breakdowns occur between the staff and patient, and underwriters are noticing more communication failures between hospitalists or the hospital and the primary care physician.

Ambulatory care is only one of many settings that may need a self-assessment, Young says, but it is a good example of how risk managers must consider all risks in the same way an underwriter will.

"Professional liability carriers want to know that risk management extends beyond the hospital walls," she says. "The fact that you are doing audits and surveys and have produced risk management plans will be very important to the underwriters and will definitely improve your credibility both within your organization and with the carrier." ■

Visit *HRM*, *ED Legal Letter* site

We now offer free on-line access to www.hrmnewsletter.com for *Hospital Risk Management* subscribers. The site features current and back issues of *HRM* and *ED Legal Letter*, also from Thomson American Health Consultants.

Included on the site and in its archives are links to every article published in *HRM*'s *Legal Review & Commentary* supplement from January 1999 to present.

There also are links to every article published in *Healthcare Risk Management*'s *Patient Safety Quarterly* and *Patient Safety Alert* supplements from January 1999 to present.

HRM's 2003 salary survey also is available in its entirety.

Find links to other web sites that are essential references for risk managers. There also is a guide to upcoming conferences and events of interest to risk managers. Click on the User Login icon for instructions on accessing this site. ■

Self-assessments correct problems and buff image

Self-assessments can be used to address known problems within the organization and also to promote a risk manager's stature, says **Kenneth W. Felton**, RN, MS, FASHRM, senior vice president and health care practice leader with Webster Insurance in Waterbury, CT, and a former hospital risk manager.

In addition to revealing issues that may have gone unnoticed, self-assessments also can be helpful when you already know you have problems that will alarm underwriters. Felton tells the story of a long-term care facility that received a notice of nonrenewal after the underwriter saw a state department of health report that showed widespread deficiencies. Many risk managers might assume that the insurer would not provide coverage, but he worked with the facility's risk manager to conduct a thorough self-assessment focusing on the problems outlined by the department of health.

"We had full commitment by administration to implement a plan of action, and we also included performance measures and internal audits that were performed at six-month intervals to monitor staff performance to the changes in policies and procedures," Felton reports. "We also did risk management education and on-site consultation."

Afterward, the insurance carrier sent an independent risk consultant to perform a risk assessment, which resulted in reinstating the insurance coverage.

Build credibility

Any self-assessment can serve as a template for determining what educational efforts are needed in the near future, Felton says. He also notes that self-assessments can be useful for the risk manager internally.

"The self-assessment helps us all as risk managers build our credibility within the institution," he says. "It also helps us empower others within the organization. It is important to use this information to show senior leadership the risk management activities performed within the organization, which builds our credibility and leadership and also engenders support for future endeavors." ■

Step-by-step process helps assess ambulatory care risk

Risk managers must investigate potential exposures with a critical eye, especially when the area in question is a new acquisition for the organization, says **Donna Young**, CPHRM, FASHRM, vice president of risk management services with Mutual Insurance Co. of Arizona in Phoenix.

Young says self-assessments are particularly important when a new physician practice, clinic, or other type of operation is acquired by the organization, but she notes that the same step-by-step process can be used to study the risks posed by any department or the organization as a whole.

To conduct a self-assessment, Young uses an ambulatory care setting to offer this advice:

1. First obtain the loss history of the facility, department, or organization. Include the loss history of the physicians involved. The carrier currently providing insurance will have a loss history. Review the history to look for any potential problem areas.

2. Using that information, develop an audit plan that includes these key areas:

• **Medical record documentation.** Look for legibility, proper corrections, and whether allergies are prominently displayed and updated. Are baseline history, chief complaint, findings, and planned treatment well documented? Is the follow-up time frame documented?

"Failure-to-diagnose claims often are related to treatment plans that called for a patient to be monitored for six months, and then the patient is seen in the office two or three times over the next year with no indication that the problem was monitored," Young says. "Is there a system in place to flag those patients and make sure that doesn't happen?"

Are diagnostic and consultative reports in the chart with physician initials and date? Are no-shows and cancellations documented? What about prescription refills/proper approval, medication summaries, evidence of communication between providers, and all phone calls (including after hours)?

"That is another area of weakness that can complicate defense of any claim," Young says.

Is patient noncompliance and/or informed refusal of recommended treatment documented?

"That information can be vital in defending future claims," she points out.

Are informed consent discussions/forms in place, including a discussion about risks, benefits and alternative treatments? Is patient education regarding health problems, medications, and plan of care documented?

"Often we will see the record with that says, 'Risks and complications discussed.' That, quite frankly, is not what you want to see," she says.

Walk around to see risks

• **Systems.** System failures play a big role in failure-to-diagnose allegations, so look for a system that tracks diagnostic test results and consult reports, a patient reminder system for important follow-up appointments or preventative screening, and a follow-up system for no-shows.

Is the telephone triage system based on protocols approved by the physician? If nurse practitioners and physician assistants work with patients, is there a system in place for physician supervision? Is there a system that will notify patients of abnormal lab results? Is there a system for discharging patients from the practice?

3. Do a walkabout. Look at the office environment, premises safety, appropriate signage, privacy notices, HIPAA compliance, handicap accessibility, prescription pad security, syringes, medications secured, and staff using nametags with appropriate designations.

"My experience is that you'll learn the most about a facility by doing a walkabout on any given day," Young says. "It's risk management by walking around. You do it in your hospitals and you can learn a lot by doing it in ambulatory care or any other area you're assessing."

4. Call the office or department. Call as if you were a patient and see how well the systems work from that perspective. How accessible to patients is the physician? Is the answering system live or electronic? Do you get lost in a loop of automated choices? How long do you wait on hold? Are same day appointments available for emergencies and emergency department follow-up? Is there an office protocol for when the doctor returns calls?

Check procedure for collections

5. Look at billing and coding. Are account receivable procedures lawful and professional? Is physician approval necessary before turning an account over to a collection agency? Is accurate

coding assured? Are midlevel providers being billed appropriately?

"Do the coders understand how to avoid pitfalls that could lead to allegations of fraud and abuse?" Young asks. "Check to see if the physician reviews the medical record prior to the business office sending the claim to collections. It's been my experience that several claims can be avoid if this occurs."

6. Develop an action plan. Make sure time lines are in place and reasonable. Include staff and physician education. Focus on communication skills as well as the basic risk management issues. Don't forget that physicians should be required to attend education programs because their attitudes often set the tone for the entire practice or department.

"Education programs are excellent ways to improve communication and explain to doctors and staff the how's and why's of steps that will improve the system," Young says. "You may also want to remind that improving documentation and management of clinical information not only improves clinical care and patient outcomes, but also reimbursement from the health plan." ■

Who might fill the role of your patient safety officer?

If you don't already have a patient safety officer in your institution, it might just be a matter of time before you do. But should you be the person who fills that role? And if you're not, how does that new position fit in with your role in the organization?

There is no doubt that the number of patient safety officers is on the increase, says **Jeffrey Driver**, JD, MBA, chief risk officer with Stanford (CA) University Medical Center and president of the American Society for Healthcare Risk Management (ASHRM). Health care organizations are seeing the value in having a position devoted specifically to patient safety, but there is great variety in how organizations set them up, he says.

Some mix risk management and patient safety together, while others keep them as distinct positions. Both approaches can be valid depending on the particular needs of the organization, Driver says. In a previous position at Beth Israel Medical Center Deaconess in Boston, he reorganized the risk management department to make all the risk manager patient safety officers. The change worked out well, partly because the hospital already had an integrated quality and risk department, he says.

"We basically eliminated walls and barriers," Driver says. "If one of your major areas of loss is your med mal area, you want to tackle that with a patient safety program; sometimes, it is best to eliminate those barriers between that effort and risk management."

More than a fad

ASHRM recently released a monograph, "The Growing Role of the Patient Safety Officer: Implications for Risk Managers." It notes that the implications for risk managers are "huge when a leadership restructures an organization" to formalize patient safety officer responsibilities. ASHRM notes that this trend gives risk managers "an opportunity to highlight their current contributions to patient safety, develop additional skills, and expand their profile."

The monograph goes on to emphasize that the move toward patient safety officers (PSOs) is much more than just the latest fad.

"Ideally, the PSO role is not merely a title change or a cosmetic change to an existing position because it is based on an emerging cultural change unlike anything that has occurred in health care," it says. "The PSO role and function should be purposefully structured to achieve the goal of a culture of safety and not as a fulfillment of some regulatory or accreditation requirement."

(Editor's note: To download the monograph, go to the ASHRM web site at www.ashrm.org and select "Monograph" from the first page. Then find the patient safety officer monograph posted on June 4, 2004.)

Career path for some

The move toward patient safety officers can be seen as a career opportunity for risk managers, Driver says. The position can be seen as a distinct career path, or it can be a growth area within your current position, he says.

Pursuing a position as a patient safety officer can present the opportunity to move beyond the traditional risk management activities, Driver suggests.

"Patient safety goes beyond the general risk management concepts of loss control into broader issues like the culture of safety, specific programs to improve patient safety, nonpunitive policies, and so forth," he says. "The risk manager has

tremendous growth opportunities in patient safety."

Can aid risk manager

But the patient safety officer is not always a risk manager. At Stanford, patient safety officers are distinct from the risk managers, but Driver says they should not be seen as any kind of threat to those who remain in more traditional risk management positions.

"If you have a patient safety officer, you have a deputy risk manager. They're helping you with loss control," he says. "It's really a partnership. You probably have enough things to do so it should be nice to have someone else who can specialize in that particular area."

Patient safety officers will hold various positions in a corporate structure, Driver says, with some reporting to the risk manager and some reporting directly to the CEO. Others go through the quality department.

"Reporting to the risk manager is not typical," he says. "Patient safety is being carved out as a distinct profession and often it originates more in quality than in risk management."

Not business as usual

Risk managers may in a position to support the addition of a patient safety officer to the hospital's structure, Driver says. Administrators may question why another, separate person is necessary to address patient safety.

"It's common to wonder why we need one person we can't afford," he says. "But if you are having a number of medical accidents, a pattern of them, or you have cultural issues that are not being addressed, the risk manager should offer support for why a patient safety officer might help."

The risk manager can help determine where the patient safety officer should fall within the organization's structure, he notes. But what if you think this is a position you should pursue yourself? Driver says the first step is to assess your own background and skills and determine how well you fit the bill.

Remember that the patient safety officer isn't just an updated name for risk managers, he notes. While some risk managers will be able to step right into the new position, some will find it more difficult.

"Some risk managers think they have been doing patient safety for 20 years, that patient safety is the same thing as traditional risk management," Driver says. "Actually, they've been looking at accidents and reacting to them, maybe putting in some proactive policies. But patient safety goes far beyond that, and you have to really stay on the cutting edge."

No need to change positions

To be effective in a patient safety role, the risk manager must be willing to study the latest theories and strategies — and new ones are coming every day, Driver says. If you are more comfortable with the more traditional risk management concerns and the tried and true techniques, patient safety may not be the position for you unless you're willing to pursue more training first.

"Plus, some risk managers realize that they are so busy with claims and other risk management concerns that they couldn't possibly get to all those patient safety issues," he says. "That's fine if you recognize that it's too much to handle and you need a separate position for it. There's no shame in saying you're going to stick with the traditional risk management because that need will always be there no matter what happens with the patient safety officer."

Driver admits that once the idea of a patient safety officer is raised, it can be difficult for a risk manager to tell superiors that you're not prepared to take on that role. The strategy at that point is to make a business case for why a separate patient safety officer would benefit the organization.

"It will be right for some people, but you don't do your employer any favors by biting off more than you can chew," he says. ■

Hallway talk can violate patient confidentiality

Have you ever been walking through the hospital and overheard staff talking about patients? So have plenty of other people, according to new research that warns such overheard conversations can be a serious breach of patient confidentiality.

The research was conducted at Purdue University in West Lafayette, IN, by **Maria Brann**, assistant professor of communication studies at West Virginia University in Morgantown, and **Marifran Mattson**, associate professor of communication

at Purdue. Their work shows patient privacy is breached when hospital employees talk about patient cases in public areas, such as the cafeteria, or with people outside of work.[1]

"The country has recently invested a tremendous amount of resources in the nation's largest set of federal privacy laws to prevent health care providers and institutions from divulging or selling patient information," Mattson says. "But we found that the daily conversations of physicians, nurses, hospital staff and technicians can jeopardize the same kind of personal information. So, not only is there a need for privacy laws, but also we see how challenging it is to maintain such laws in the simplest setting of people talking to each other."

Mattson says the research should be a warning to health care risk managers. She suggests that they "seize the opportunities to teach privacy awareness and skills."

Frequent breaches of privacy

Mattson notes that hallway conversations can constitute breaches of HIPAA, which protects patients' medical information and limit access to that information.

Brann agrees, saying the research was prompted in part by what she observed while volunteering at a hospital as an undergraduate at Purdue.

"I noticed several instances when health care providers would discuss patients' information with other health care workers without being very discreet," she says. "Even though the study was conducted before the health insurance act was law, I don't think we would see a great difference in our results."

For the study, Brann only recorded observations in places that were accessible by hospital visitors, such as hallways, elevators, waiting rooms, and cafeterias. Fifty-one patients also were interviewed about medical privacy.

"Confidentiality breaches are occurring daily," she says. "While health care providers may not be malicious in their disclosures, they are still sharing patients' most personal information with unauthorized individuals, which has the potential to create problems for the patients."

Staff talk freely at home

Brann notes that disclosure of patient information can lead to identity theft, discrimination, or social stigma if a medical condition or patient identification information is inadvertently revealed. The most common breach found in the study was in casual conversations between employees at workstations or in the cafeteria, where hospital personnel discussed health information about patients and co-workers.

Privacy also was violated when the public could overhear phone conversations with insurance companies or other medical consultants in which patients' phone numbers, addresses, and Social Security numbers were given. In one extreme example, a receptionist even spoke to insurance companies on speakerphone.

Health care providers sharing information with their family members also was a concern. Many of the subjects interviewed in this study acknowledged that their family members and friends who work in health care shared patient stories. Most of the subjects justified their loved ones' breaches of privacy as acceptable because their family members and friends were cautious about not revealing too many details.

"Even without identifying the patient by name, there is cause for concern, especially in a smaller community," Mattson says. "The most serious consequence is that people will find out about loved ones' health problems from someone other than their health care provider. Just as concerning is that if patients realize their personal information is vulnerable, then they may be less likely to share important details with their physicians or nurses."

Brann and Mattson advise risk managers to remind health care staff about how easy it is to divulge patient information inadvertently. Most breaches occur without the speakers even realizing that they are being careless with patient information, so simply making people aware of the danger is a big part of solving the problem, Brann says.

"Health care providers need to pay attention to how they personally breach confidentiality laws, and patients need to bring breaches of privacy to the attention of their physician, nurse, medical assistant, or waiting room receptionist," she says. "When you overhear a phone conversation in a waiting room where the receptionist is repeating personal information, such as Social Security numbers, gently remind the person or supervisor that you are concerned."

Reference

1. Brann M, Mattson M. Toward a typology of confidentiality breaches in health care communication: An ethic of care analysis of provider practices and patient perceptions. *Health Commun* 2004; 16(2):231-251. ■

Surcharge at the heart of covering high insurance

A practice of 150 obstetrician-gynecologists in Connecticut is planning to charge an extra $500 per pregnancy starting Sept. 1 in response to its high medical liability premiums, even though the state attorney general say such a surcharge probably is illegal.

The group, Women's Health Connecticut, based in Avon, released a statement saying the surcharge is intended to force a solution to the state's medical malpractice crisis. The practice will forego the surcharges if state legislators pass meaningful medical malpractice reform, a spokesman says.

Patients will be billed directly if employers or insurers don't pay the surcharge, the practice reports. Connecticut Attorney General **Richard Blumenthal** says the plan is "most likely illegal." He recently urged any patient charged the fee to contact his office so that investigators could respond.

"This sizeable surcharge raises serious and significant legal questions, and I am investigating its potential violations of laws or contracts," he says. "Any woman charged this $500 fee should immediately contact my office, because it may in fact be not only illegitimate, but an illegal requirement. I sympathize with physicians who face increasing medical malpractice costs — particularly obstetricians and gynecologists. But imposing a surcharge is unreasonable and unauthorized, unless the doctors are able to negotiate it with the health care coverage providers."

Blumenthal says the fee also threatens to deter pregnant women from seeking health care. The $500 surcharge, or any fee that contradicts a physicians' contract agreement with an insurance company or other health benefits provider, would violate state law in most instances, he says. Medicaid requires a participating provider to accept only what Medicaid pays for covered services.

Beyond insurance payment

In the case of insurance plan subscribers, the surcharge appears to violate statutes "which plainly say that enrollees can't be billed for any sums owed beyond what the insurance company would pay — except for copays and deductibles," Blumenthal says.

In mid-May, Connecticut Gov. John G. Rowland vetoed tort reform passed by the state Legislature. Physician groups supported the veto because the bill did not contain a cap on noneconomic damages. Women's Health Connecticut announced its surcharge plan days after the veto.

The group said proceeds would go to a special fund to pay for liability premiums, which it said rose from $250 per delivery in 2002 to about $1,000 currently. The group pays $98,750 a year in premiums per doctor and expects that figure to rise to $100,000 to $125,000. The practice delivers 12,000 babies a year. ■

Doctor sues to fight for rights of whistle-blowers

A physician in California physician recently sued the Florida Medical Association (FMA) in Tallahassee and three other doctors in an effort to fight what he says is an attempt to discourage doctors from testifying against others in medical malpractice suits. His attorney tells *Healthcare Risk Management* that the "peer review" programs sometimes promoted to discourage hired guns in malpractice cases really amount to witness intimidation.

John Fullerton, MD, of San Francisco, accuses the defendants with abusing economic power and with using the FMA for a corrupt purpose. He is seeking damages for defamation and an injunction that would stop the FMA's recent efforts to subject courtroom testimony to "peer review."

A case in Tampa

A Florida native, Fullerton filed the lawsuit after testifying for a plaintiff in a medical malpractice case in Tampa. The jury returned a verdict in favor of the defendants, but the three physician defendants complained to the FMA with a letter alleging that he committed perjury and manipulated testimony for personal gain. They asked that Fullerton's testimony be reviewed by the FMA's "peer review" program.

John Vail, JD, Fullerton's attorney and a representative of the Center for Constitutional Litigation in Washington, says the physician sued because he felt besmirched by the attacks on his credibility. Vail says. "John Fullerton is a good doctor and a good citizen, and the allegations made against him are outrageous."

An FMA official says the charges are baseless and the group fully expects to prevail in this matter. **Jeff Scott**, JD, FMA's associate general counsel, says the FMA's peer review system merely is a way to review comments from concerned physicians and that the information they provide "may be valid and it may be improper, false, or fraudulent. We're merely looking at the information as you would in any peer review system." **(See excerpt from Fullerton's complaint, below.)**

Expert review

According to Vail, two independent experts have reviewed Fullerton's testimony and pronounced it scientifically sound. The FMA created its peer review program after the American Medical Association (AMA), with the urging of Florida physicians, adopted resolutions endorsing such programs, to be modeled on a program run by the American Association of Neurological Surgeons (AANS).

"You won't see witness intimidation in any of the documents creating these programs," Vail says. "But when the AMA passed the resolutions, the AANS had reviewed approximately 40 cases, all of them involving witnesses who testified in favor of plaintiffs. Not a single case of bad testimony in favor of a doctor. Do the math."

The FMA, a private organization, allows physicians to make complaints about other physicians, regardless of whether the other physicians are members of the FMA. Fullerton is not.

Once a complaint is made, other physicians review it.

"Amazingly, the FMA program has no standards by which you can judge what testimony will be found lacking," he says. "Doctors huddle, and if they don't like what you've said, you get the medical equivalent of a scarlet letter." ■

Complaint: 'Peer review' of witnesses is intimidation

This is an excerpt from the lawsuit filed by **John Fullerton**, MD, a San Francisco physician who accuses the Florida Medical Association (FMA) in Tallahassee of intimidating doctors who testify in medical malpractice cases:

- **Conspiracy Through Abuse of Economic Power**

"Defendant FMA and its agents designed, implemented, and administered a program to review doctors who serve as expert witnesses in an attempt to intimidate, hinder, and deter them from continuing to appear as expert witnesses in meritorious medical malpractice cases.

"As part of its program, Defendant FMA actively encourages the submission of any type of complaint and/or allegation of misconduct regarding doctors who appear as experts in medical malpractice proceedings. [The physician defendants], in response to Defendant FMA's invitation, published a letter on or about July 11, 2003, which intentionally made false and unprivileged allegations about Plaintiff Fullerton's conduct while serving as an expert in a medical malpractice case . . ."

The complaint goes on to accuse the defendants of "acting in concert for the common purpose of intentionally and maliciously harassing and intimidating Plaintiff Fullerton so as to prevent him for serving as an expert witness in other meritorious medical malpractice cases." It also charges that the FMA is using its peer review program as a method for "intimidating, harassing, and hindering Plaintiff Fullerton by holding the threat of sanctions over him should he continue to testify as an expert in official court proceedings." ■

Nurse stole pain meds from dying patients, police say

Michigan Attorney General **Mike Cox** recently announced charges against a Howell, MI, nursing home nurse supervisor that accuse him of stealing prescription painkillers from hospice patients.

Jeffrey Joseph Wolos, 32, of Swartz Creek, MI, was arraigned in 53 District Court in Howell. The charges arise from a chain of events at Medilodge nursing home in Howell culminating on Dec. 8, 2003.

Cox says prosecutors intend to show that Wolos tampered with and stole patients' pain-relief medications and delivery systems. He faces three charges: one count of knowingly possessing a Schedule II narcotic drug, a four-year felony; larceny by stealing prescription medication, a four-year felony; and physical abuse or harmful neglect of a patient by removing or diminishing the strength and content of prescribed medications for control of chronic pain, a one-year misdemeanor. ■

AMA says Massachusetts joins those in liability crisis

The American Medical Association (AMA) recently announced that Massachusetts has become the 20th state in a full-blown medical liability crisis due to its deteriorating medical liability climate and the growing threat of patients' losing access to care.

Using recent data from the Massachusetts Medical Society, the AMA cautioned that patients' access to care may be in jeopardy as increased medical liability costs force physicians to restrict the services they provide, including no longer performing trauma surgery or delivering babies. High-risk specialists in Massachusetts reducing their scope of practice include 50% of neurosurgeons, 41% of orthopedic surgeons, 36% of obstetricians, and 29% of general surgeons.

Reports from the Massachusetts Medical Society indicate that there are only 23 neurosurgeons based outside of Metro Boston to serve 39 hospitals, and the time to recruit a neurosurgeon has increased from nearly 23 months in 2002 to nearly 30 months in 2004.

Massachusetts now joins Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming as states in crisis. ■

Reader Questions

Outpatient clinic can be OK for injured employees

Question: The answer to a recent reader question suggested that injured employees be treated in the employee health department instead of the emergency department (ED), but what if you don't have an employee health department? We only have an employee health nurse, so could employee falls be treated in the outpatient clinic?

Answer: In the previous article, **Mark Hakim**, BS, MA, MBA, risk management consultant with ProAssurance Corp., an insurer in Okemos, MI, cautioned that well-intentioned efforts to provide quality care in the emergency department could backfire. The reason involved the dual-capacity doctrine, which means that an employer who is normally immune from tort action because of workers' compensation laws may be liable for additional damages as a party who has committed a wrongful or negligent act beyond its role as employer.

When an employee is treated for on-the-job injuries, that doctrine can mean that if the employee stays in the employee health department, in most cases, the hospital is just an employer responsible for workers' compensation claims. But if the employees goes to the ED, the employer also could be exposed to malpractice claims or other allegations that any patient might bring.

Treating an injured employee in the ED also may create additional risks for violating HIPAA and other privacy concerns. **(For more on that risk, see *Healthcare Risk Management*, March 2004, p. 34.)**

Hakim says the question regarding whether an outpatient clinic would suffice raises a good point. Unfortunately, the answer is not simple.

"Risk management often becomes a balancing act between the risk of providing the appropriate medical care and other risks, for example, potential allegations of medical malpractice, breach of patient confidentiality, and so on," he says. "In other words, where does the greatest risk exposure lie?"

It is important to remember that workers' compensation laws vary from state to state, Hakim says, so it would be wise to consult with legal counsel experienced in this area. Beyond that, he stresses that getting the patient the best available medical care is always sound risk management even when that patient is your employee.

That may include having the patient treated in an outpatient clinic or an ED if those are the most appropriate resources available in your organization.

"When that is the case, it may be worthwhile to provide the outpatient clinic and ED staff, both clerical and clinical, with some training relating to the specifics of treating employee injuries, HIPAA, and other concerns," he says. "Another possibility would be to develop some very specific triage algorithms for work-related injuries. Working with the input of an occupational medicine physician and an ED physician, you develop guidelines for what injuries can be seen by the employee health nurse and what needs to go to the ED." ▼

Diplomacy required when patients want to leave ED

Question: How much do we really have to encourage people to stay for treatment in the emergency department (ED) when they want to leave? I understand that it can be considered an EMTALA violation if they leave without being seen and say it was because they didn't feel welcome. But how much encouragement is enough?

Answer: It is true that you could be accused of an EMTALA violation if patients say they left because the ED staff made them feel unwelcome, says **M. Steven Lipton**, JD, an attorney specializing in EMTALA interpretation with the law firm of Davis Wright Tremaine in San Francisco. And that could include letting patients walk out the door because the wait is too long.

The tricky part is knowing how much to persuade them to stay, he says. Some action is necessary, he says, but ED staff do not have to beg and plead with patients.

"The hospital is expected to first take no action or say anything that would discourage anyone from remaining for the medical screening examination and possibly stabilizing treatment," he says. "If a patient indicates that he or she would like to leave or intends to leave, then the hospital must remind the patient that they will provide the exam if the patient will wait."

If the patient still wants to go, the hospital has no obligation to further persuade him or her to stay. The key, Lipton says, is that the hospital *is* obligated to make clear that the patient is welcome and that an examination will be provided if only the patient will wait. But once that assurance has been provided, the hospital is not liable for the patient leaving.

From a risk management perspective, the tricky part can be proving that ED staff actually provided that assurance.

"It may be helpful for the receptionist or triage nurse to include some note in the chart that the patient wished to leave, along with whatever other facts might be appropriate, and that he was told a screening exam would be provided if he stayed," Lipton says. "A note like, 'Patient decided to leave despite offer to provide examination' would be a good addition to the chart."

The situation becomes stickier when the patient wants to leave because he or she is concerned about the financial liability for treatment. In those cases, some guidance is provided by the Centers for Medicare & Medicaid Services (CMS), which in a 1999 advisory bulletin explained exactly what the ED staff should do in response to a question about financial liability. *(Editor's note: To see the entire advisory bulletin, go to www.hortyspringer.com/content/EMTALA_SAB_Nov10_1999.htm. Financial inquiries are addressed in item 4.)*

That CMS guidance indicates that the government expects ED staff to reassure people that they will be treated as needed without regard to payment, even going to great lengths if necessary to avoid answering a question about how much the treatment will cost. That can create difficulty when ED staff think patients have a legitimate reason to ask what the payment obligation will be and when patients are frustrated with not getting a direct answer.

If the patient insists on a straight answer, CMS allows the ED staff to respond only after exhausting all attempts at stonewalling.

The advisory bulletin outlines a series of steps intended to reassure the patient and deflect payment inquiries. Only after going through those steps can the staff member answer the question about payment. ■

COMING IN FUTURE MONTHS

- Criminal investigations: Balancing patient privacy
- Nonprofit hospitals face class-action suit
- Risks from patient-owned equipment
- Workers disciplined for photographing patient

CE objectives

After reading this issue of *Healthcare Risk Management,* the CE participant should be able to:

1. Describe legal, clinical, financial, and managerial issues pertinent to risk managers in health care.
2. Explain how these issues affect nurses, doctors, legal counsel, management, and patients.
3. Identify solutions for hospital personnel to use in overcoming challenges they encounter in daily practice. Challenges include HIPAA and EMTALA compliance, medical errors, malpractice suits, sentinel events, and bioterrorism.
4. Employ programs used by government agencies and other hospitals (such as EMTALA, HIPAA, and medical errors reporting systems) for use in solving day-to-day problems. ■

CE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

5. According to Kenneth W. Felton, RN, MS, FASHRM, which of the following is true?
   A. Underwriters are taking a harder look at health care providers, conducting a more detailed assessment of risks and liability exposures.
   B. Underwriters are not looking as closely at risks and exposures as they have in the past because the insurance market has softened.
   C. Underwriters are looking more closely at risks and exposures only for those with a history of claims in certain problem areas.
   D. There has been no change in recent years regarding how closely underwriters are assessing health care clients.
6. According to advice offered by Donna Young, CPHRM, FASHRM, what should be the first step in conducting a self-assessment of risk and exposures?
   A. Walk through the facility or department to look for obvious problems.
   B. Go to staff and physicians to ask them what they think the biggest risks are.
   C. Gather information on loss and claims history.
   D. Study billing records for potential oversights.
7. What did Maria Brann find was the most common way health care workers breached patient confidentiality in the workplace?
   A. Discussing patients at the workstation or in the cafeteria.
   B. Asking patients about other patients
   C. Leaving documents with patient identifiers in plain view
   D. Speaking too loudly in patient rooms
8. According to M. Steven Lipton, JD, what does EMTALA require when a patient wants to leave the emergency department without being examined?
   A. Nothing
   B. The emergency staff must assure the patient that an examination will be provided if he or she will stay.
   C. The emergency staff must talk the patient into staying.
   D. The patient must be examined immediately before leaving.

Answers: 5. A; 6. C; 7. A; 8. B.

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Unnecessary and negligent surgical procedure leads to death and a $1.4 million verdict

By **Jan J. Gorrie**, Esq., and **Blake Delaney**, Summer Associate
Buchanan Ingersoll Professional Corp.
Tampa, FL

News: One summer day, a man was scheduled to have surgery to remove his gallbladder. Upon the recommendation of his gastroenterologist, however, the patient underwent an endoscopic retrograde cholangiopancreatography (ERCP) first. Negligence during the ERCP caused the man to develop pancreatitis, which in turn required the originally scheduled gallbladder surgery to be performed by way of an open laparoscopic cholecystectomy. During the patient's follow-up visits, the same doctor failed to recognize abnormal test results and failed to re-hospitalize the man. The man died six weeks after the original ERCP procedure. The decedent's family filed suit against the doctor, resulting in a $4.7 million award from the jury. California caps on medical malpractice verdicts reduced the award to $1.4 million.

Background: On June 13, 2000, a 46-year-old real estate agent was scheduled to undergo surgery to remove his gallbladder. When he arrived at the hospital, his gastroenterologist, who was not board-certified, recommended an ERCP, in which a doctor uses an endoscope to diagnose various problems of the gastrointestinal tract. The doctor recommended the ERCP because he thought there was a gallstone in the common bile duct.

Three hours after the procedure, the patient required hospitalization for ERCP-induced pancreatitis. An ERCP normally has a complication rate of 10%, and the specific complication of pancreatitis occurs in 1%-5% of all cases. While hospitalized, a general surgeon went ahead with removal of the patient's gallbladder by means of a laparoscopic cholecystectomy. Because of adhesions and fluid from the pancreatitis, the surgeon had to perform the operation using an open procedure. During the gallbladder removal surgery, an X-ray showed there were no gallstones in the common bile duct, contrary to what the gastroenterologist had thought.

The surgeon and gastroenterologist discharged the patient, but required a follow-up visit the next month. Consequently, the man returned to the clinic for a CAT scan on July 6, at which time his doctors further required him to return to the clinic from July 19-21 for additional testing. Despite abnormal results from the CAT scan on July 6, the doctors did not hospitalize the patient, instead sending him home on July 21. After continuing to experience problems, the patient went to his local hospital on Aug. 16 and was subsequently transferred to a larger hospital on Aug. 18. Doctors at the second hospital performed two emergency surgeries, but the man died on Aug. 29.

The man's widow and two minor children filed suit against the gastroenterologist, arguing that the ERCP procedure was needless and caused the decedent to develop pancreatitis. Relying on testimony from five expert witnesses, the plaintiffs alleged that the doctor was liable for failing to give full and complete informed consent, for failing to disclose three possible alternatives to the ERCP, for having recommended and performed the ERCP, for negligently performing the procedure when he cannulated the pancreatic duct, for failing to re-hospitalize the patient on July 21 after an abnormal

CAT scan, and for committing a battery upon the decedent by intentionally misrepresenting the need for an ERCP.

The defendant countered with four expert witnesses to show that the standard of care was met in all instances and that no misrepresentations were made. The defendant asked the jury to return a defense verdict, but in the event the jury decided to impose liability, then to return damages in an amount considerably less than what the plaintiffs had requested. The jury found there was medical negligence and failure to obtain informed consent, but concluded there was not a medical battery. The jury awarded the plaintiffs $4.7 million, including $1.7 million for loss of past and future household services and $3 million in general damages. California caps on medical malpractice verdicts, which limit noneconomic damages to $250,000, reduced the award to $1.4 million.

What this means to you: "This case highlights potential concern in the areas of communication, informed consent, appropriate certification, and general risk management protocol," observes **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, CHT, past president of the American Society for Healthcare Risk Management and director of risk management services for the Miami Jewish Home and Hospital for the Aged.

The lack of communication between the gastroenterologist and the general surgeon likely contributed to the alleged negligence in this case. Kicklighter recommends investigating whether the gastroenterologist documented his justification and indication for performing the ERCP, and whether he communicated these findings with the general surgeon. Specifically, "if the gastroenterologist performed the ERCP just before the scheduled gallbladder surgery because he thought there was a stone in the patient's common bile duct, then one might question the timing of the procedures, especially if the surgeon were not included in the decision," she says.

The risk management department would certainly want to explore whether it was imperative for the gastroenterologist to identify a gallstone before undertaking the surgery and, if so, whether he had communicated this need to the general surgeon, Kicklighter says. Moreover, it may be that the gallbladder surgery was not performed at the most opportune time, given the complications that arose during the ERCP, she adds.

The gastroenterologist's conduct also raises concerns about informed consent, even though the jury ultimately concluded that there had not been a medical battery. The duty to provide informed consent imparts a responsibility upon the physician greater than simply explaining to the patient what is going to happen during the procedure.

"Were all the risks, benefits, and alternatives thoroughly discussed with this patient by both the surgeon and the gastroenterologist prior to the ERCP and the surgical procedure?" Kicklighter asks.

Although a hospital's consent form confirms that the patient is satisfied with and understands the implications of the upcoming treatment, the ultimate duty to provide the patient with information to be able to make an informed decision regarding consent always falls on the physician performing the procedure.

Finally, the hospital's risk management department should ensure that its protocol provides the hospital with the best possible protection from liability. For example, the hospital's gastroenterology lab should have reported the alleged negligence to risk management at the time of the procedure, or as soon thereafter as practicable, so that risk management could follow up with the situation. Further, guidelines should identify the lead physician in situations where a specialist and surgeon might end up working together, such as at a postoperative clinic visit. Kicklighter also recommends implementing policies whereby independent practitioners are clearly identified to the public so as to limit the hospital's vicarious liability in situations where a specialist or surgeon incurs liability.

Reference

• Tulare County (CA) Superior Court, Case No. 01195845. ■

Classic appendicitis goes undetected, leads to death

News: A man with no prior abdominal problems presented to an emergency department (ED) complaining of severe abdominal pain in the area of his appendix. Based on X-ray findings, two physicians made an incorrect diagnosis of gastroenteritis and discharged the patient from the ED without performing a CAT scan. The next day, the patient rushed from his home to a second ED. Despite evidence of a distended abdomen, wildly fluctuating white blood count, and subnormal temperatures, a CAT scan was for the second time not performed.

The patient eventually began to lose consciousness and died from a full cardiac arrest that evening. After the patient's family brought suit against both hospitals and the attending physicians, the parties settled the case prior to trial for $1.6 million.

Background: A 34-year-old male with no previous medical complaints or underlying conditions presented to the ED of Hospital No. 1 for care and treatment. He had experienced an eight-hour bout with extreme nausea and vomiting combined with severe abdominal pain. The pain was specifically located around the umbilicus. Upon examination, the patient's bowel sounds were hypoactive, and he was remarkably tender to palpation. The ED physician ordered chest X-rays, and the flat and upright exposures revealed the presence of a 3.7 by 2.7 centimeter calcification in the right lower quadrant.

Based on the X-ray findings, the ED physician requested a surgical consult. The consulting physician evaluated the patient by ultrasound and ultimately ruled out the possibility of gallbladder disease. Nevertheless, the consulting physician recommended proceeding with a CAT scan, which never was actually ordered or performed. Without performing any additional evaluation, the two physicians made an incorrect diagnosis of gastroenteritis and discharged the man.

On the following morning, the patient was taken by ambulance to Hospital No. 2's ED, where he was seen and admitted. Before his transfer from the ED to the surgical floor, 2,000 cc green fluid were removed from the patient by means of a nasogastric tube. The patient continued to register clear complaints of intolerable abdominal pain and reported he had been unable to eat; he was posturing in excruciating pain and there was evidence of decreased bowel sounds. Medical personnel administered morphine, which had no effect on his reports of pain. A CAT scan was ordered but never performed.

The attending physician noted the patient's abdomen was distended, with increased pain on palpation. By this time, his white blood count was 8,000, with the first bands being recorded at 24%. Later in the morning, his white blood count fluctuated from 8,000 to 1,900, then back to 3,600. Neither the attending physician nor staff reacted to the lab results and, during the course of the afternoon, medical personnel continued to ignore the patient's abnormal lab values. The patient also registered subnormal temperatures, which went unnoticed and, when morphine failed to relieve the patient's pain, Demerol was ordered instead. By the time the attending physician ordered X-rays, the patient could hardly stand. By 3:45 p.m., a Swan-Ganz catheter had been inserted and a nasogastric tube was draining "coffee-ground material" with evidence of discolored discharge. By 5 p.m., the patient's abdomen was again noted to be taut and distended, with no detectable bowel sounds. Shortly thereafter, for an unknown reason, the patient was transferred to a post-anesthesia care unit, but an anesthesiologist did not see him until 6 p.m. The anesthesiologist recognized that the patient was in tremendous pain, was experiencing difficulty breathing, and was in a life-threatening crisis. The patient's vital signs were taken, and his blood pressure reading was obtainable. The patient began to lose consciousness and ultimately went into full cardiac arrest at approximately 6:15 p.m. Resuscitative efforts were unsuccessful, and the patient was pronounced dead at 6:45 p.m.

The decedent's survivors brought claims against the three treating physicians and both hospitals for the negligent care and treatment of the patient. The plaintiffs argued that the patient presented with a surgical abdomen, and they alleged that Hospital No. 1 and its two physicians were negligent in their failure to diagnose the presence of simple appendicitis. The plaintiffs argued that despite the decedent's classical, clear presenting signs and symptoms, the defendants failed to follow up with the standard of care mandated to affirmatively rule out the presence of appendicitis through the use of a CAT scan and/or other diagnostic modalities — none of which were ever ordered or performed. The plaintiffs further averred that had those diagnostic studies been performed, the decedent would have been able to undergo a timely appendectomy and would been able to make a successful recovery with no residual deficits. Rather, those defendants made an incorrect and negligent diagnosis of gastroenteritis, after which they discharged the patient from the ED.

With respect to Hospital No. 2 and the third treating physician, the plaintiffs claimed that they, too, failed to timely diagnose and treat what was a clear case of appendicitis. The plaintiffs also placed considerable fault on the staff of the hospital for not properly monitoring the patient and failing to alert the attending physician when abnormal lab results began appearing and when the patient's pain would not subside with medication.

The parties settled the case prior to trial for $1.6 million. The breakout of damages among the defendants is unknown.

What this means to you: This case highlights several causes of preventable hospital errors, including poor communication among staff, overworked or minimally trained workers, a shortage of appropriately trained staff, and a faulty system of checks and balances.

"Unfortunately, this case illustrates how the lack of fail-safe mechanisms in the health care delivery system can expose patients to unnecessary injury, including death," says **Ellen Barton**, JD, CPCU, a risk management consultant in Phoenix, MD.

The sequence of events at the ED first visited by the patient illustrates the importance of providing appropriate medical care throughout a patient's stay. "While it appears that the ED physician in Hospital No. 1 initially treated the patient appropriately by scheduling X-rays and a surgical consultation, the lack of follow-through on the recommendation for a CAT scan was an error in judgment by the ED physician and by the consulting physician," states Barton.

Errors in judgment often can be prevented by protocol. "When the consulting physician recommended a course of action, the ED physician needed to have affirmatively accepted or rejected the recommendation, thus providing an opportunity for further consideration," she continues. Thus, it is likely that it was a system error in that the recommendation for a CAT scan was not responded to as a matter of procedure.

Hospital No. 2 also committed a series of errors that led directly to the patient's death. "First, the fact that the patient had been seen the previous day in another hospital's emergency department is a clear signal to heighten scrutiny," says Barton.

But while the patient was appropriately admitted to the surgical unit, it appears that there were significant errors in judgment and system failures.

"The second hospital failed to provide appropriate medical care for the plaintiff by ignoring the patient's lack of response to morphine and Demerol, never performing a CAT scan despite an order to the contrary, and failing to react to the patient's lab results or additional symptoms. Further, the patient's transfer to a post-anesthesia care unit is unexplained by the facts presented and appears to be inappropriate," Barton says.

EDs must have appropriately credentialed medical and nursing staff. In this case, the physicians failed to order appropriate tests for what turned out to be a classic case of appendicitis. But the problem runs deeper than individual errors in judgment.

"Given the particularly volatile nature of emergency departments," Barton says, "a hospital must have systems in place that would have concurrently reviewed the care. . . . Both the nursing staff and attending physician would have benefited from systems that would have triggered alerts both when the CAT scan was not performed and when no action was taken in response to the patient's continuing pain."

Thus, despite correctly admitting the patient, Hospital No. 2 subsequently failed on numerous occasions to adhere to the appropriate standard of care. In addition to eliminating the preventable errors that surfaced throughout this case, hospitals should also ensure their own financial protection in cases where physician negligence is the sole cause of injury. In this case, it is likely that the first ED physician was under contract with the hospital and operating as an independent medical practitioner.

"In such cases," Barton advises, "it is important that the hospital contract for physician services include: 1) a provision requiring adherence to JCAHO [Joint Commission on Accreditation of Healthcare Organizations] and other regulatory standards; 2) a hold harmless/indemnification clause protecting the facility from physician liability; 3) ED group acknowledgment that each physician is engaged in the private practice of medicine and is not an agent of the facility; 4) specified limits of professional liability insurance coverage, with a carrier acceptable to the facility; and 5) a dispute-resolution provision.

"It is also important that signs are posted in the emergency department triage and treatment areas notifying patients that the physicians providing care are independent contractors. In addition, emergency department physicians should not wear lab coats or badges that contain the name of the hospital. Finally, the emergency department admission form should clearly state that the physicians providing care in the emergency department are independent contractors," she adds.

From the patient's perspective, this case also illustrates how important it is for the patient to have an advocate. "While a patient advocate is never a substitute for appropriate care, someone who knows the patient, can accompany the patient to the hospital, can ask questions, and will insist that the nursing and physician staff be responsive to the patient's needs could make the difference between life and death," states Barton.

She concludes, "It is no surprise that this case was settled prior to trial."

Reference

- Baltimore City (MD) Circuit Court, Case No. _____. ■

HIPAA Regulatory Alert

Supplement to Healthcare Risk Management and Hospital Access Management

Many health care organizations still remain a long way from security compliance

URAC identifies four barriers to meeting security demands

Even though less than a year remains before the HIPAA security rule takes effect April 21, 2005, many health care organizations are a long way from compliance, according to an assessment by Washington, DC-based URAC, the only organization offering a security accreditation program based directly on the HIPAA security rule.

Written to minimize potential disruptions and security breaches to personal or protected health information (PHI), the HIPAA security rule affects:

1. how health care organizations interact with information systems that contain PHI;
2. methods by which organizations communicate with consumers, providers, and other third parties;
3. ways that health care organizations educate patients and obtain information about them;
4. the manner in which PHI is collected, used, and shared both internally and externally.

URAC officials say their accreditation review experience has identified four barriers that are hampering the ability of health care organizations to satisfactorily meet security rule demands:

1. Incomplete or inappropriately scoped risk analysis efforts. Risk analysis — formal identification of an organization's risk tolerance, outstanding risk liabilities or residual risk, and prioritization of subsequent risk reduction activities — is the fundamental building block of any security management program. The government will look to an organization's risk analysis as a primary piece of evidence when investigating security complaints and determining an organization's rationale for reasonable and appropriate controls. URAC says risk analysis as required by the security rule is a much more demanding evaluation of an organization's security posture than that from a typical vulnerability assessment.

2. Inconsistent and poorly executed risk management strategies. According to URAC, risk analysis and risk management are linked to ensure a sound security compliance strategy. Security risk management deals with allocating resources to gain the highest level of risk reduction possible within the bounds of an organization's risk tolerance. URAC says organizations must be careful not to rely too much on technologists to make risk management assumptions without clear guidance and support from the business operations perspective. All the organizations it surveyed were found to have serious issues with policy and procedure documentation, management, and implementation.

3. Limited or faulty information system activity review. According to URAC, the purpose of information system activity review is to provide an accurate history of system activity in the event of a security breach, and allows health care organizations to track system usage; reconstruct, review, and examine events; and detect and verify unauthorized users and processes.

4. Ineffective security incident reporting and response. According to URAC, much of the confusion surrounding the security incident response and reporting requirement centers on the question of what constitutes a security incident and what constitutes a sufficient level of reporting. The rule defines a security incident as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system." This element is closely linked with the other three, URAC says, because the ability to identify security incidents is heavily

dependent upon information system activity review, practicable mitigation requires an organization to have established risk tolerances as part of its security management process, and harmful effects must be linked to an organization's knowledge of its threats, vulnerabilities, and impacts.

Improve compliance preparations

Based on its consulting experience. URAC has recommendations to improve preparations for security rule compliance, including:

1. Health care organizations must focus on implementation of a sound security risk management process that includes a comprehensive, meaningful, and realistic risk analysis, risk management program, information systems activity review function, and security incident reporting and response process.

2. HIPAA implementation efforts should be managed in the broader context of overall business risk.

3. Health care organizations should begin preparations now because most security risk management programs can take up to a year to implement.

According to URAC, HIPAA compliance should not be seen as a costly regulatory burden, but rather as a way to appropriately manage ongoing security risks in a way that reduces overall business risk, reduces costs, and improves quality.

(Editor's note: The report can be downloaded from www.urac.org.) ■

OCR reports more than 5,000 complaints

Largest number filed against private practices

As of April 2004, the Department of Health and Human Services' Office of Civil Rights (OCR) had received more than 5,000 complaints from individuals about alleged HIPAA privacy violations. New Haven, CT-based Wiggin & Dana attorney **Jennifer Wilcox** says the largest number of privacy complaints was lodged against private practices, followed by hospitals, pharmacies, and health plans.

By the end of June, OCR had closed 48% of the complaints, including many that were settled easily on jurisdictional grounds — such as complaints involving problems before the compliance date, complaints against noncovered entities, and complaints filed more than 180 days after an incident. Wilcox says the complaints that OCR decided warranted further investigation fall into three broad categories: lack of adequate safeguards such as leaving charts in public areas or computer screens exposed to patients, etc.; improper accessing of protected health information, such as employees accessing protected information for nontreatment related reasons; and impermissible disclosure of protected information to third parties not involved in treatment.

According to Wilcox, OCR has received a large number of complaints about failure to disclose protected health information to family members. Although such a failure is not a HIPAA violation, OCR says it has provided technical assistance to providers who are the subject of such complaints so they realize that HIPAA permits such disclosure in many instances.

"Questions of disclosure to family members have received a lot of media attention since the HIPAA privacy act compliance date," she says, "and many providers who initially adopted very strict policies may be relaxing their approach due to the backlash. While providers may wish to be flexible in adapting their policies based on customer and patient feedback, they still need to remember that improper disclosures to family members can have serious implications."

To date, OCR has not sought civil monetary penalties or other official sanctions for any cases it has investigated. Wilcox says agency officials have indicated that providers have been cooperative with investigators, readily strengthening their policies or implementing training efforts in response to complaints. According to the OCR director, she reports, 50 complaints have been referred to the Department of Justice, the agency charged with investigating and enforcing criminal violations of HIPAA rules. OCR staff also indicated there are no plans to institute audits, compliance reviews, or other efforts to affirmatively look for violators.

Few court cases have yet addressed the HIPAA privacy rule, Wilcox says, although some courts have considered the privacy rule's pre-emption provisions in connection with several discovery requests and subpoenas. Analyses and interpretations of the courts that have looked at the provisions suggest that HIPAA pre-emption will be a difficult issue for courts to deal with in coming years, as seen in these decisions:

• A federal court in Louisiana ruled that HIPAA was more protective of patient privacy than state law, even though state law allowed patient records to be disclosed only with patient consent or based on a court order entered after a hearing.

• A federal court in Maryland concluded that HIPAA pre-empted a Maryland law that requires health care providers to disclose to defense legal counsel medical records relating to a patient's health, health care, or treatment that forms the basis of a civil action instituted by a patient, without the patient's authorization.

• A New Jersey state court said HIPAA did not pre-empt a practice authorized by state Supreme Court precedent in which defendants in all personal injury cases are permitted to conduct informal interviews with plaintiffs' treating physicians as long as specific patient authorization requirements are met. The court determined that the interviews did not conflict with the general principles of HIPAA and, as HIPAA does not expressly address informal discovery, New Jersey law should govern the practice. But it required that the authorization forms used be revised to meet HIPAA requirements.

• The question of HIPAA pre-emption also has come up in two courts that were addressing the constitutionality of the Partial-Birth Abortion Act of 2003. During discovery in those cases, U.S. Attorney General John Ashcroft issued subpoenas to several hospitals in New York and Illinois seeking medical records of women on whom certain abortion procedures had been performed. The court issued a protective order requiring elimination of certain identifiable information. In both cases, physicians argued that more stringent state laws precluded the disclosure. In the New York case, the court decided that the New York law did not apply to federal cases, while the Illinois court said that Illinois law applied because it was more stringent. The Seventh Circuit has affirmed the decision in the Illinois case, while the Second Circuit has stayed the New York court's order pending its decision. The government has withdrawn its subpoena for the New York hospital records, and Wilcox says it is thus unlikely the appeals court will rule on the legal questions.

Compliance deadlines

Extended deadlines for some compliance tasks have arrived, and covered entities should be sure they are up to date. Wilcox says covered entities were required to execute business associate agreements with vendors by April 14, 2004, and providers should be reviewing their contract process to be sure all existing vendor agreements are reviewed and business associate language added where appropriate.

Also, small health plans (spending less than $5 million on premiums or health care costs) had an additional year to comply with the privacy rule. Many of the smaller plans are fully insured and have significantly fewer compliance obligations. Wilcox advises organizations that sponsor benefit programs for their employees to review the nature of the benefits and be sure they are aware of what their compliance obligations are. Common programs such as flexible spending accounts that reimburse medical expenses or employee assistance programs may be considered HIPAA-covered entities, she says, and even smaller self-insured plans require compliance steps.

The HIPAA security rule compliance date of April 21, 2005, is the next major hurdle. Wilcox says HIPAA security implementation needs to be structured and documented according to the security rule's standards and implementation specifications. Although specific information technology solutions will help in achieving many of the security standards, she says, there also are organizational, systemic, and documentation issues that must be addressed. ■

Working Group concerned about claims rejections

Slow-Pay modification is at issue

The HIPAA Implementation Working Group, a coalition formed to help providers and vendors better understand the process by which the HIPAA electronic standards are developed and modified and to increase provider and vendor representation in that process, has contacted Centers for Medicare & Medicaid Services (CMS) administrator **Mark McClellan** to express concern over a CMS instruction to fiscal intermediaries to reject claims lacking certain data elements not needed by Medicare for claims adjudication.

The Working Group letter, signed by the American Hospital Association, American Medical Association, Association for Electronic Healthcare Transactions, Laboratory Corp. of America Holdings, and WebMD, urged that

CMS go no further in enforcing data content specifications and to focus instead on implementation of other transactions that will reduce administrative costs and benefit all participants in the health system.

The groups noted that because of the complexity and cost of the changeover to meet new administrative simplification standards, few trading partners were prepared to exchange HIPAA standard transactions on the Oct. 16, 2003, deadline, and CMS has permitted use of contingency plans during the transition phase as payers, clearinghouses, and providers continue to work out the thousands of details upon which successful transactions depend.

In its role as a payer, CMS also adopted a contingency plan for Medicare to ensure continuation of health care payments and provision of health care services while the transition effort is under way. The CMS contingency plan includes continued processing of health care claims submitted in the old "legacy" format while providers and payers resolve problems experienced exchanging transactions in the new HIPAA format.

Slow-Pay

The Working Group says health care providers and Medicare carriers and fiscal intermediaries have effectively used the contingency plan period to progressively migrate to the HIPAA format with limited disruption in health care payments or services, but contends that migration now is in jeopardy because of CMS' Slow-Pay modification that the Working Group says is contrary to the HIPAA objective of reducing administrative costs and increasing efficiencies.

Under Slow-Pay, fiscal intermediaries were told to reject institutional health care claims missing specified data elements not needed by Medicare to adjudicate the claims. The Working Group maintains the change in policy increases the data-collection burdens of and financial risks to providers.

"CMS explained its action to enforce data content specifications by stating that private payers require Medicare to include this data when submitting claims through coordination of benefits transactions," the Working Group wrote. "We suggest that it is counterproductive to accommodate the demands of what we believe are a very small minority of payers when those demands will provide little or no benefit for those payers, impose added burdens on all providers, and bring no return on the providers' investment of time and energy.

"We request that, going forward, CMS adhere to the principles of reducing administrative costs and increasing efficiency as outlined in the statute when implementing HIPAA. It is inconsistent with these principles to enforce extended HIPAA data content specifications prior to achieving systemwide format compliance for claims and implementation of other covered transactions that will bring immediate and systemwide cost savings." ■

Vendors agree on HIPAA interpretation 43% of time

The HIPAA Conformance Certification Organization (HCCO) says its Common Compliance Assessment Process determined that, on average, the nation's leading HIPAA translation and validation vendors agree in their interpretation of compliance 43% of the time, up from an average of 35% on all transactions in 2003.

The assessment is an advanced testing process that performs detailed analysis of HIPAA compliance edits across all vendors simultaneously. Testing takes place in a neutral environment to uncover compliance differences among participants and work to align edits. Participants in the 2003 and first quarter 2004 testing represent some 80% of the translators and validators installed in U.S. health plans, HCCO says.

"We have come a very long way, but there is still much work to be done in the process of aligning compliance edits in HIPAA translation and validation software," says HCCO chairman **Mark Lott**. "Many of the differences can be traced to differences of opinion within the language of the implementation guides, but with the help of X12, the authority for interpretation, we have made great strides in moving this key initiative forward. A very important result of the CCAP testing effort is that while differences of interpretation are present in the beginning of the testing process, all vendors have the same interpretation upon completion of the program. To date, CCAP has tested more than 1,100 transactions representing close to 100,000 various compliance edits, and through this effort the majority of the industry has the same understanding of compliance." ■